OHA
Office of the Healthcare Advocate
STATE OF CONNECTICUT

Memorandum

To: Interested Parties

From: Victoria L. Veltri, JD. LLM, State Healthcare Advocate

Date: February 13, 2013

Per your request, the following is a chronology of the OHA/DSS Project.

It is important to note that when OHA proposed a partnership with DCF for recovery of funds for the Voluntary Services Program, both parties came to the table immediately and began working under an informal arrangement prior to execution of a formal MOU. That MOU took only a month or two to execute. The collaboration with DSS did not resemble the same level of partnership status until September, when counsel from DSS became involved, although even their involvement did not prevent additional delays in execution of the MOU.

On May 8, 2012, the day the legislature passed the budget revisions for FY 2013, I began the process of trying to engage DSS staff in this collaboration. On May 21, 2012, we had our first meeting, including DSS QA staff. DSS was to meet with its existing vendor HMS within two weeks of that meeting and was slated to contact me once it received some requested information from HMS. By June 13th, I requested another meeting, but to no avail. I then asked Commissioner Bremby to meet with me and his staff. That meeting took place on July 3rd.

We responded to questions raised at the meeting on that same day. While we were still waiting for information from HMS, we were asked by DSS to let them know for which provider groups we would be able to do appeals. The request from DSS was made on July 13th. I responded the same day and on July 16th with some additional information.

With no information forthcoming from HMS and no response to my July 16th response, I sent another e-mail on July24th inquiring as to the status of the process. On July 26th, DSS responded with information that HMS was preparing a claim sample for our review.

On August 8th, with no additional communication, I once again sent an e-mail to DSS staff requesting the status on the project, pointing out that OHA was close to hiring and wanted

to start the project as soon as possible. HMS sent claim files for our review the next day. We reviewed the files and made some comments and asked a few questions, the last of those on August 12th.

With no response to our questions, on August 18th, I once again e-mailed DSS requesting a response to our questions, letting them know we had hired two people and requesting to see the draft MOU since I was going on vacation on August 31st and wanted to wrap up the MOU before I left. On August 20th, HMS responded to my questions of August 12th. On August 21st, DSS responded to my request for the draft MOU by stating it would have to be reviewed by the DSS legal staff and would need to be updated with some information from HMS before I could review it. DSS staff said it would be at least another couple of weeks before I could see the MOU.

On August 24th, exasperated with the length of this process, in addition to replying to the DSS staff person, I contacted Commissioner Bremby, requesting that he direct his staff to share the draft MOU so that it could be negotiated in partnership and as quickly as possible. Finally on August 29th, DSS' legal staff got involved at the direction of Commissioner Bremby and shared the draft MOU with me. A flurry of e-mail exchanges on the language took place in the two days before my vacation began on August 31st

OHA and DSS staff met on September 19th to complete the negotiations—some negotiations were conducted via e-mail while I was on my vacation-- around the MOU. DSS legal staff and OHA agreed to the substantive terms of the MOU on that day. DSS had some technical requests that we responded to that same day. On September 24th, DSS legal staff sent us a near final version of the MOU and again requested the information we had already sent to the QA staff on September 19th. (QA staff did not inform legal staff that OHA previously had sent over the requested information on September 19th.)

While the substance of the MOU, including its attachments was finalized by the end of September, OHA and DSS legal staff could not complete the MOU without additional information from DSS QA staff on obtaining addresses for clients who needed to be contacted to alert them to OHA's appeal of denials by their private insurer for services paid for by Medicaid. As of October 3rd, that information had not yet made it to DSS legal staff and OHA, despite OHA's response to the QA staff's request on September 19th.

On October 10th, with no response from DSS QA staff, I sent a direct e-mail to Commissioner Bremby raising serious concerns about the continued delays by certain non-legal DSS staff on this project that was threatening the savings in the budget for this fiscal year. (I can provide that e-mail or any of the documents related to the history provided herein.)

On October 11th, DSS QA staff responded to DSS legal staff inquiry. On October 12th, the MOU was finalized, and on October 17th, OHA received the first transmission of data files. OHA staff is working diligently on the cases sent by HMS. We are working out some final issues on read only EMS access to obtain client addresses.

On November 1, 2012, OPM Secretary Barnes requested an update on the project with DSS. In preparation for a response, I contacted DSS QA staff to request information on the total of available claims for OHA to pursue. Despite the $20 million figure in the budget, DSS told me that OHA would not receive more than $8 million per year in denied claims to pursue. I reported that OHA would not achieve the savings figure in the DSS budget, and I estimated that OHA might achieve $4 million in savings. See my memorandum to Secretary Barnes of November 7, 2012, attached.

OHA requested a copy of DSS' contract with HMS. On November 21, 2012, OHA received a copy of the contract, but was informed that the contract had expired. HMS continued to work under a letter of intent while a new contract was being negotiated. (OHA has not been informed if a new contract was negotiated.) The original contract and amendments are attached.

After discovering significant problems with the data over a month of analysis of the data, I wrote to DSS Commissioner Rod Bremby on December 12, 2012, requesting a meeting to discuss the problems with the data and an audit of the HMS contract and the vendor's performance. (I had hoped that an audit would be performed prior to DSS' entering a new contract with HMS.)

To date, I have not received a response to my memorandum.

OHA continued to analyze the data supplied by HMS to us via DSS from the first data set and a second data set transmitted on December 21, 2012. The second set of data raised similar concerns as the first set. See the attached report on data.

As a result of the overwhelming number of issues raised by the data and the intensive investigation that OHA has been forced to engage in to organize and analyze the data, OHA has been unable to achieve any recoveries to this point.

OHA has been able to finally appeal some claims. Project staff has begun an appeal process for 10 claims that in total reflect approximately $500,000.

OHA/DSS Medicaid Reclamation Project Data Report 1-28-13

OHA received initial data set in mid October 2012 containing 7,005 claims representing $8,315,192 of Medicaid payments and covering dates of service (DOS) 11/09 through 12/09. Connecticut statute CGS 17b-265 permits a three-year look back for subrogation.

The next data set was due to OHA in November, but none was forthcoming.

Follow up inquiries to DSS QA staff resulted in our next data set being sent in mid December, containing 595 claims worth $478,496 for DOS from March 2007 through July 2012, 77 or 13% of which were too old to pursue under subrogation. However, 19 of these claims occurred during the period covered by the initial data set and, per the terms of the MOU, should have been included in that data. None have been identified as duplicate, which raises concerns about how the DSS vendor, HMS, is selecting, filtering and sharing the data.

MOU DSS OHA Fully Executed.pdf

The project contemplates total disclosure of the data for each given period subject to the agreed upon filters, but the demonstration of claims not included initially raises questions about this process. In addition, 16 claims representing $18,879 might have been actionable, but they arrived at OHApast the subrogation period soley due to the delay in delivery of the data.

The final data set OHA received contained 623 claims worth $592,220, 50, which represented$132,399 in Medicaid payments that were too old to pursue under subrogation. This final data also included claims from 2004, well past the 2009 three year cut off for subrogation, supporting OHA's concerns about the accuracy of and methods used to provide the data required under the MOU.

To date, OHA has received a total of 8,227 claims representing $9,385,910 in Medicaid payments. Ninety-six (96) of these claims, worth $173,987 or nearly 2% of the total amount, were never actionable under the project.

94.45% of the claims received have been submitted to the carriers listed in the data we received from HMS,, although a response has only been received for 42% of the total claims with additional clarification required from the carriers to assess the merits of the majority of those.

To date, OHA Project staff has identified an array of issues surrounding the data supplied by the HMS. The table below summarizes the issues identified through analysis of approximately 10% of the overall data. This analysis portrays these issues as accurately as the HMS data and information received from the carriers permit.

Data Issue	Implication	Medicaid paid	Number of claims
Active policy		$8,548.00	4
- Denial code listed as DOS Not Eligible, but member was active on DOS	If HMS relied on same data, opportunity to correct error and pursue reimbursement lost.		
Carrier paid		$59,849.00	34
- Data reflects DSS payment as primary, but EOBs showcarrier paid allowable amount	DSS' HMS's data indicates claim denial by carrier, resulting in DSS payment as primary when member had little or no residual liability.		
Denial Reason Incorrect		$518,623.00	110
- General catch all for claims that may have been pursuable but for the listed denial	Inaccurate documentation / lack of integration of carrier eligibility files implicates accuracy of claim adminstration		
Duplicate claim		$3,194.00	7
- Claim submitted at least twice; data reflects	Inaccurate claim processing, often replicates DSS payment for single		

payments	claim, compounding data errors		
Local Plan		$80,218.00	38
- Per Anthem CT, none of the members listed as theirs were in fact Anthem members. The claims needed to be submitted to the local BCBS plan for processing but, based on the data, were never pursued.	Due to the age of many of the claims, there may no longer be an option to file due to timeliness. Anthem CT indicated that the DSS HMS was informed that these claims needed to be submitted to the local plan, despite the conflicting denial reasons listed.		
Missing Information		$78,015.00	19
- Claimsubmitted, additional information requested by carrier never sent by provider or DSS.	Primarily simple administrative corrections that would have enabled accurate and timely processing of these claims. Instead, many were listed as DOS Not Elig and DSS paid as primary, despite available commercial payor.		
Never member		$20,521.00	20
- Data incorrectly identifies client as subscribed to carrier, but no record of client ever having active coverage.	Failure to follow up on erroneous data led to loss of ability to file. Since the data was clearly inaccurate, this should have triggered a review of these claims to identify where the error occurred, if there was commercial coverage under a different carrier or if the client misrepresented their coverage.		
No Claim		$189,883.00	76
- Carriers have no record of having ever received these claims for processing.	While many of these claims were likely for clients whose commercial coverage had termed, the inaccurate documentation of these claims made it impossible for the HMS to identify those claims that may have been reimbursable.		

- One carrier has no record of any of 364 claims	This represents all of the existing claims for this carrier received from the vendor. The complete lack of any evidence that these claims were ever received for processing by the claim administrator, coupled with the clearly inaccurate denial reasons (many DOS Not Elig) listed by the HMS, reinforces concerns about the HMS's data management and internal tracking and audit processes.	$210,767.00	364
Overpayment		$6,263.00	15
- Data indicates that DSS paid more than was required	Multiple bases for this category. One data entry from the HMS listed the Medicaid paid amount as 20% more than the *total provider charge*. Examination of 22 EOBs from just one carrier shows that Medicaid paid much more than the client's residual liability following commercial reimbursement of the allowable amount. Example: Allowable amount of provider charges was $2,932.96 with a $100 member co-pay. Carrier paid. Data reflects that Medicaid paid $663.37, $553.37 more than the client's liability.		
Policy Termed<1yr		$151,486.00	90
- Member's policy had terminated less than one year prior to DOS	No significant issue, due to proximity of plan termination to the date of service		
Policy Termed>1yr		$143,358.00	78
- Member's policy had terminated between one and three years prior to DOS	Local carriers report providing Member Eligibility Files to HMSHMS routinely so that claims for members whose policies had termed would not be submitted, thereby minimizing the administrative burden		
Policy Termed>3yr		$15,303.00	39
- Member's policy had terminated more than three years prior to DOS	Local carriers report providing Member Eligibility Files to HMSHMSr outinely so that claims for members whose policies had termed would not be submitted,		

	thereby minimizing the administrative burden.		
Timely Filing		$7,990.00	3
- Carrier reported receiving claim after the submission deadline.	If the lack of timely filing was the provider's error, Medicaid should not have assumed primary liability. No obvious indications of HMSHMSattempts to mitigate payment in these cases.		
Wrong Carrier		$8,149.00	11
- The data lists the wrong carrier as providing primary coverage for the member	Inaccurate data and/or failure to follow up to identify if any alternate coverage is active, as well as why the data was incorrect eliminated the possibility of claim recovery from the correct commercial carrier, if any.		
	Total Medicaid payments linked to issues	$1,502,167.00	908

Office of the Healthcare Advocate
STATE OF CONNECTICUT

Memorandum

To: Roderick Bremby, Commissioner, Department of Social Services

From: Victoria Veltri, State Healthcare Advocate

Re: Medicaid Recoveries Project—Significant Concerns/Issues

Date: December 12, 2012

This follows my memorandum to Ben Barnes of November 7, 2012, which laid out concerns re the delay in the start of this project and DSS' statement that OHA would only receive a maximum of approximately $4-8 million per year in denied claims on which to pursue recovery, despite the budget projection of $20 million. See Attachment A.

I write now for several additional reasons concerning our collaboration on Medicaid recoveries as required under the current budget. Since our MOU was signed on October 17th, OHA began in earnest to take the data provided to us by HMS and turn it into a route to recover revenue for the state. However, in our analysis of the data provided, our review of some of the claims we've received and our discussions and exchanges with some of the carriers, we have identified serious issues surrounding the operation of the current TPL recovery by HMS that warrant your attention and investigation.

Specifically, upon our initial review of the claims provided to us by DSS, through HMS, the TPL vendor, we have discovered that much of the data provided to OHA is inaccurate or raises concerns.

1. A significant portion of the claims submitted as denied due to DOS Not Eligible were well past the plan's termination date, in some cases by a decade.
    a. Excerpt from a response from ConnectiCare concerning the claims we submitted for evaluation (the full comment is contained in Attachment B):
        i. The first member on the report, Cheryl W., is a good example. She appears 22 times with claims from 2010. Conducting a search by both name and ID number, we show that the member's coverage

terminated here on 12/31/1999. As we had mentioned in our recent conference call, this is an example where we've received and denied 133 claims for this member and services are more than a decade beyond their term date (2010-2011).

ii. The fourth member appearing on the list, Jessica N., has three claims on the report for dates of service in 2010 and 2011. Our eligibility records indicate she termed coverage with us on 01/12/2000. This member currently has 42 denied DSS claims on file for services being well after their eligibility period. This is troubling, as ConnectiCare has indicated that they routinely send updated eligibility data to HMS (see Attachment B).

2. Carriers have identified IDs provided in the HMS data that are inaccurate or do not exist in the carriers' systems. In many cases, carrier representatives worked with OHA staff to verify eligibility/enrollment using multiple identifiers, including name, DOB, SSN, charge amounts and DOS without identifying a member, irrespective of eligibility.
    a. Of 18 claims submitted to Anthem CT, none were Anthem CT members, and our contact was only able to identify the correct BCBS plan based on the data provided for two of the claims.
    b. 18 claims from New ERA Life Insurance were submitted to us. Of the 18 claims, none of the policy and group numbers were in its system. Nor were the client's name and social security numbers in the system. The carrier had no information in the system.
    c. None of the IDs for claims submitted to BCBS TX are valid.
3. Many of the DOS provided do not match the actual DOS.
4. Several carriers have indicated that the claims submitted were denied for not being submitted to the local plan.
    a. The HMS data included 2 Empire claims for one client over two years old coded DOS Not Eligible that should have been submitted by HMS to the local BCBS plan for processing. Carrier reps provided additional information about a total of 98 claims for this same member, totaling over $200,000 in charges and of 11 EOBs received to date indicate that DOS from June 2009 through December 2010. Ten were for treatment in the Emergency Room totaling nearly $20,000, but all were denied for lack of submission to the local plan. Given that these EOBs indicate that CT-DSS is the provider, that claims exist in the HMS data for this member during this period, and the apparently variable accuracy of that data, OHA is concerned that there may have been additional claims for this member that were improperly processed. These claims would never have been pursued had OHA not investigated them.
    b. To date, we have identified several similar denials for failure to bill to the local plan first for BCBS RI cases, with additional detail pending on the majority of this carrier's claims. Again, HMS' failure to submit these claims

properly on DSS' behalf would not have been discovered but for our intervention.

5. 442 claims list "Paid to Provider" as the basis for denial. Of these 358 were processed under the Medicaid managed care program/Medicaid MCO. OHA staff was never informed that a "70" prefix on the DSS ICN number indicated enrollment in a Medicaid MCO. It took OHA and carrier staff several days to determine that a CT Medicaid MCO was involved in these claims. Since these claims were paid under the Medicaid managed care contracts or were incurred under the MCO contracts, OHA is unsure why it received these, when DSS is not at risk for these claims.
6. Fraud case from BCBS-Minnesota
    a. One case involved multiple dates of service spanning several months with total charges of $15,726.89 and Medicaid payments of $3,062.78. The denial rationale listed includes Not Eligible, DOS Not Eligible, Purged Claim, No Coverage and Service Not Eligible. However, BCBS MN informed our staff that these had been denied as part of a fraud investigation. The member was employed by and worked in Minnesota and was present at work in Minnesota during each of the dates of service and therefore could not have received the services charged. Also troubling is the fact that this member had active Medicaid resided in Minnesota at the time.
7. Commercial carriers have reported that some of the claims listed as denied in the HMS data are not reflected in their systems as ever being submitted for processing.
    a. BCBS MN had no record of receiving claims for two of the members.
    b. This is a trend across multiple carriers.
8. Pequot Nation Fund paid claims for its members in March 2012 for dates of service prior to March 2012, but data provided by HMS to OHA in October 2012 show that the claims were not paid by the Pequot Nation Fund as "date of service ineligible". HMS files have not been reconciled to reflect payment of claims.
9. ConnectiCare, Aetna, United Healthcare and Diversified have reported a significant number of the claims that were submitted for processing were duplicative and had already been processed and, in many cases, paid. In addition, ConnectiCare indicated that HMS would send thousands of claims at a time and that the majority of those were duplicate cases. Representatives at ConnectiCare had discussions with representatives of HMS in the fall of 2011 to discuss this issue and to request that this practice be addressed. Following that discussion, HMS did not submit any claims until mid-October 2012. That submission to ConnectiCare which included over 3,100 cases (2011 & 2012) and 70% of those claims are duplicate claims that were previously sent to them by HMS. Carriers are reporting significant administrative costs to comply with repeated submissions of claims that have been repeatedly denied. OHA staff has requested that United Healthcare assess their ability to identify additional administrative costs associated with these duplicative claim submissions. United will supply OHA with the data when available.

It is important to understand that OHA's analysis of the HMS data is still in the early phases; the initial data includes over 7,000 claims from 163 distinct carriers/employer funds/third party

administrators spanning 2 ½ years. We have been working to identify contacts with these carriers with which we do not already have contacts, transmitting the claims data and, once the carrier has time to evaluate and respond to our document, requesting and assessing each claim. This process has identified the concerns briefly discussed above, but has also, as OHA staff has looked at these claims in detail, frequently indicated a need for more in depth analysis and further requests for information from the carriers.

OHA undertook this project as a result of the budget revisions for the current fiscal year. We did so keeping at the fore a core OHA principle to identify, pursue efforts that prevent cost-shifting to the state:

> **III. Healthcare industry watchdog; cost shifting practices burden the State's economy, providers, payors, and consumers.**
> A. We identify deceptive, misleading, unreasonable, and unfair practices and collaborate to solve them.
> B. We take proactive and precautionary measures to prevent healthcare consumer issues.
> C. We reconcile, remediate, and return cost-shifted gains to the public economy.
> D. We facilitate ethical practice and understanding across industry stakeholders.
>
> See OHA's principles at http://ct.gov/oha/lib/oha/documents/final_draft_-_oha_principles_for_determining_policy_action.pdf

The current budget sets a policy to ensure that we exhaust all efforts to recover unnecessary Medicaid expenditures. Like you, I am very concerned about the level of Medicaid recoveries, especially given our state's budget circumstances and potential efforts to restrict Medicaid services because of lack of available funds. Your staff is projecting approximately $66 million and $69 million in denied commercial claims for Medicaid recipients in SFYs 2014 and 2015, respectively. To maximize our recovery, we must maintain a partnership based on intensive efforts to oversee the existing recovery efforts that DSS currently employs.

Based on our very substantive concerns about our collaboration thus far, I suggest a meeting to discuss the data provided to OHA. Given the problems we're discovering in the data, the significant contingency recovery amounts attached to activities under the HMS contract and the need to verify the accuracy of the information obtained by HMS, I recommend an independent review of the TPL contract. Such a review would include an investigation of the accuracy of HMS's transmissions to carriers and employer funds, the accuracy of HMS' verifications of coverage, the number of repeated submissions to carriers/employer funds, the number returned one or more times to DSS as ineligible for the reason that the enrollee no longer participated in the plan, the accuracy of the eligibility files maintained by HMS based on repeated submissions by carriers of updated files, the number and amount of eligible claims that should have been pursued—those that were denied for reasons that unjustifiably weren't

pursued by HMS. Most importantly, a review should tie the payments made under the contract to the above requested information.

OHA will pursue claims as rapidly as possible, given the morass of problems we are encountering with the data files provided. Our staff's time has been devoted almost exclusively to sorting through the problems and inaccuracies in the data provided. However, this recovery effort warrants prompt attention to ensure maximum recovery with maximum efficiency that does not add significant burdens and administrative expense to insurance carriers, third-party administrators and employer funds and does not delay recovery of funds.

Attachments

A. Memo to Ben Barnes, November, 7, 2012
B. E-Mail from ConnectiCare to OHA re duplicate claims

ATTACHMENT A

November 7, 2012

Benjamin Barnes
Secretary
Office of Policy and Management
450 Capitol Avenue
Hartford, CT 06106-1379

Re: Medicaid Recoveries

Dear Secretary Barnes:

I write in response to your memorandum of November 1st requesting detailed information on the Office of the Healthcare Advocate's (OHA's) progress on the Medicaid initiative and the anticipated increase in recoveries for FY 2013, as well as the upcoming biennium.

As you know the legislature passed the budget, P.A. 12-104, on May 8, 2012, and the Governor signed it on June 8, 2012. OHA received a signed Memorandum of Understanding (MOU) for this project from the Department of Social Services (DSS) on October 12, 2012. The $20 million in budgeted savings is unachievable. It is important to note that OHA did not represent that it could achieve this level of savings—in fact, OHA did not know what universe of claims would be available for the project. We were informed by DSS that instead of the $20 million figure in the budget, DSS' contractor, HMS, could provide us with only approximately $8 million in total claims to be pursued this fiscal year based on the selection criteria agreed to by the parties. (Any change in the selection criteria would result in a significant increase in the number of claims provided, and such an increase would overwhelm our existing resources.) Because of the delay in the return of the MOU to OHA by DSS, OHA projects a more likely savings of $4-5 million in this fiscal year. [1]

[1] I will be happy to provide you with additional documentation concerning the delay in execution of the MOU.

DSS has provided us an estimate of the universe of claims (approximately $4-8 million per year) available to OHA from DSS for the next biennium—see attached.) OHA has asked DSS to provide information on whether there are additional claims that OHA can pursue of the estimated $66-$69 million referenced in the attachment of denied claims for the next biennium.

DSS chooses to use a third party vendor, HMS, for some claims reclamation. DSS only makes available to OHA claims that HMS has not pursued or has stopped pursuing.

For OHA to achieve $20 million in each of the next two years of the biennium, the claims will have to exceed that amount in each of the next two years. DSS has clearly stated that this is not possible, given the current arrangement with HMS.

OHA received its first monthly claims files from DSS on which we will base our appeals processes on October 17, 2012. The first set of claims files, which comprise two years worth of select claims, total $8.3 million. OHA staff already has created an efficient process by which to pursue appeals of denied claims with 163 in-state and out-of-state insurers and union funds.

We continue to believe that this will be a productive project that should produce savings in the budget. OHA has been as proactive as possible in initiating this project.

Please contact me with any questions at 860-297-3989.

Very truly yours,

Victoria L. Veltri
State Healthcare Advocate

Encl

C: Roderick Bremby, DSS Commissioner
John McCormick, DSS Director of Quality Assurance
Lee Voghel, DSS Director of Finance and Administration
Paul Potamianos, OPM Executive Budget Officer
OHA Advisory Committee

Veltri, Victoria

From: Zimmerman, Craig S.
Sent: Wednesday, November 07, 2012 12:10 PM
To: Veltri, Victoria
Cc: Bremby, Roderick L.; Voghel, Lee; McCormick, John F.
Subject: Projection for Biennium for Medicaid recoveries

Per your request, according to HMS they estimate that they will bill $115 million in SFY 2014 and $121 million in SFY 2015 to Health Insurance Companies. In addition, they estimate that $66 million and $69 million will be denied by these companies in SFY 2014 and SFY 2015 respectively. If we continue with the current selection criteria, OHA would receive approximately $4-8 million yearly in claims. Please let me know if you need anything else from us at this time. THANKS.

From: Veltri, Victoria
Sent: Sunday, November 04, 2012 8:00 PM
To: McCormick, John F.; Zimmerman, Craig S.
Cc: Bremby, Roderick L.; Voghel, Lee
Subject: Projection for biennium for Medicaid recoveries
Importance: High

As you know, Ben Barnes has sent a request asking for an update on the Medicaid recoveries project and savings projections for each of the next two fiscal years. OHA is not in a position to make a projection on the amount of rejected claims that will be made available to us over the next biennium. DSS and HMS are the entities that hold this information. Based on the budget language—a goal to increase recoveries to 10%, I would need a projection from you of the estimated amount of rejected claims to answer Ben's question re the next biennium.

I am requesting that such an a analysis be completed in order to assist Ben and the legislature in planning for next year's budget. Thanks.

Victoria Veltri JD, LLM
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ATTACHMENT B

Email from ConnectiCare

We had an opportunity to review a sample of the 200 claim spreadsheet that was sent to us last week.
Here are some initial findings:

* The 200 claims on the report are not from unique members as 34% (67 of 200) are multiple entries from the same members.
* Of the 20 or so members that have been reviewed so far, all have DSS denials in the claim history for services incurred outside the member's eligibility period. We have not seen any other denial reasons so far.
* The first member on the report, Cheryl W., is a good example. She appears 22 times with claims from 2010. Conducting a search by both name and id number, we show that the member's coverage terminated here on 12/31/1999. As we had mentioned in our recent conference call, this is an example where we've received and denied 133 claims for this member and services are more than a decade beyond their term date (2010-2011).
* The fourth member appearing on the list, Jessica N., has three claims on the report for dates of service in 2010 and 2011. Our eligibility records indicate she termed coverage with us on 01/12/2000. This member currently has 42 denied DSS claims on file for services being well after their eligibility period.
* Another is Lisa K. who appears on the attached report twice. She has 13 DSS claim denials on file for dates of service from 09/11/09 to 08/17/12, 10 from 2010. Each is after her term date of 08/31/09.
* Member Rita M. is listed on the report three times and has 21 DSS claim denials on file for dates of service ranging from 2010 to 2012. The termination date shows as 07/04/07.
* One more for now is Rebecca Z. who has 10 claims on the report. The member id actually points to dependent Amanda who currently has 65 denied DSS claims on file for 2010. Their term date is showing as 08/01/09.

These five examples above help demonstrate the issues we've been having with HMS claim submissions in recent years. These alone combine for 274 claim denials on file, all for the same reason. They are part of the thousands of claims submitted to us annually by HMS that deny as member not eligible or as duplicates.

Do you have an understanding if or how HMS is extracting member eligibility dates? I believe we send an eligibility file that includes this information.

We can keep working through the report as time permits and I suspect we'll see much of the same.

Let us know if you have any questions.

Thanks...Jim

2013 Program Report Card: Office of the Healthcare Advocate (OHA)

Quality of Life Result: All Connecticut residents, irrespective of race/ethnicity, socioeconomic status, age or gender, have equal access to all essential healthcare services and are effective self-advocates through a better understanding of their rights and responsibilities under traditional and managed care health plans.

Contribution to the Result: In 2012 OHA achieved this via: outreach to assist consumers to make informed decisions on health plan selection; assisting consumers to resolve grievances with health plans; and identifying and taking up systemic issues that required regulatory or legislative intervention.

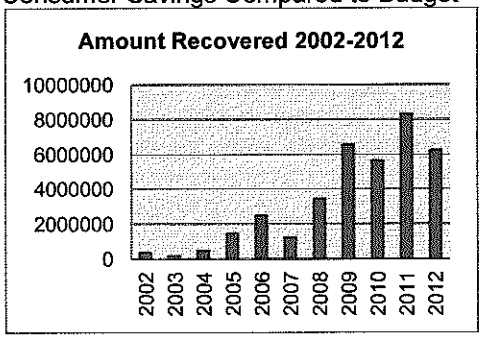
Program Expenditures	State Funding	Federal Funding	Other Funding	Total Funding
+Actual FY 12	$1,022,482	$396,224		$1,418,706
*Estimated FY 13	$2,293,407	$412,135		$2,705,542

+Includes funding for Commission on Health Equity of $134,140.00.
**This number includes $447,118.00 for 4 DSS project positions and $101,400.00 for 1 DCF project position, Commission on Health Equity two positions of $256,616.44 (DSS and DCF project services are reflected in separate program report cards.)*

Partners: Consumers of Connecticut, Office of the State Comptroller, DCF, DSS, DDS, DPH, Universities, health care providers, health insurance companies.

How Much Did We Do?

Consumer Savings Compared to Budget

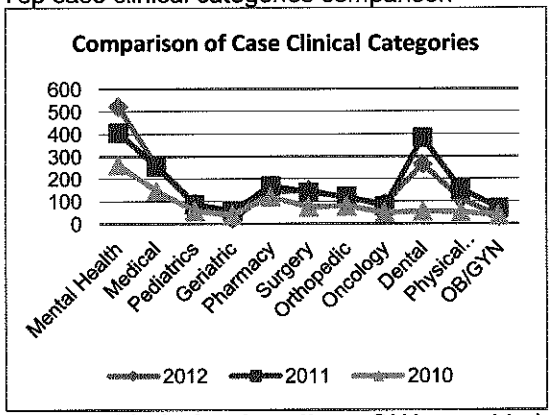


Story behind the baseline: Savings $6.0 million in 2012 The slight downward savings in 2012 from 2011 is attributed to lost productivity due to substantial staff medical leaves, the loss of a seasoned case manager in early 2012 and several cases in 2011 with unusually large case savings. As the federally designated consumer assistance program under the Affordable Care Act, OHA is the consumer resource for those with questions about their healthcare plans. OHA anticipates savings to consumers to continue to increase and thus the trend will continue to increase.

Trend: ▲

How Well Did We Do It?

Top case clinical categories comparison



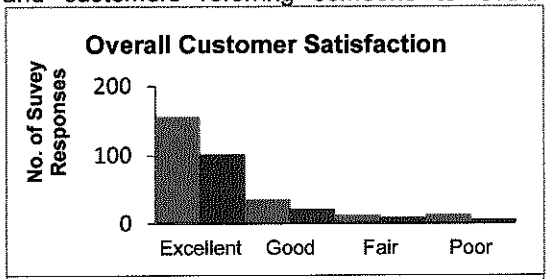
Story behind the baseline: OHA provided assistance in many different clinical categories. The upward trend in the number of mental health and substance use (MH/SU) and medical cases continues. MH/SU denials continue to be the number one clinical category of cases, due in part to personal referrals from previous customers and targeted outreach. OHA has engaged all stakeholders to ensure that denied MH/SU services are appropriately reviewed based upon individual need.

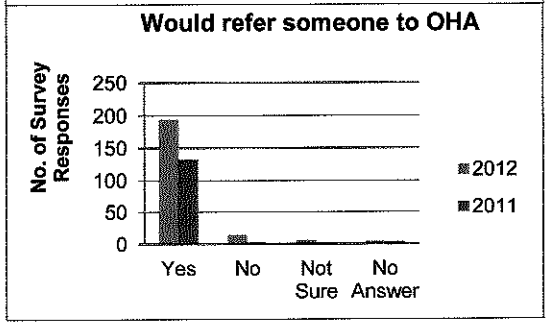
Trend: ▲

How Well Did We Do It?

Customers will be satisfied with the value the work of OHA and will refer others to OHA.

Story behind the baseline: There is an upward trend in overall customer satisfaction and customers referring someone to OHA.





Trend: ▲

2013 Program Report Card: Office of the Healthcare Advocate

Quality of Life Result: The third party liability recovery process in the Medicaid program will be more transparent and accountable to Connecticut residents.

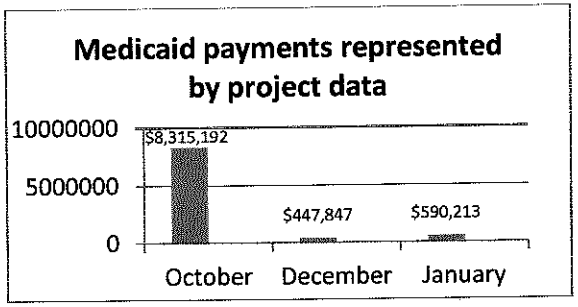
Contribution to the Result: In 2012 the Office of the Healthcare Advocate and the Department of Social Services collaborated on a special project which has resulted in the discovery of needed improvements in the recovery efforts and data processing in the third party liability process.

Program Expenditures	State Funding	Federal Funding	Other Funding	Total Funding
Actual FY 12	$0.00	$		$0.00
Estimated FY 13	$ 447,118.00	$		$ 447,118.00

Partners: Consumers of Connecticut, DSS, health care providers, health insurance companies.

How Much Did We Do?

Potential state savings under the project

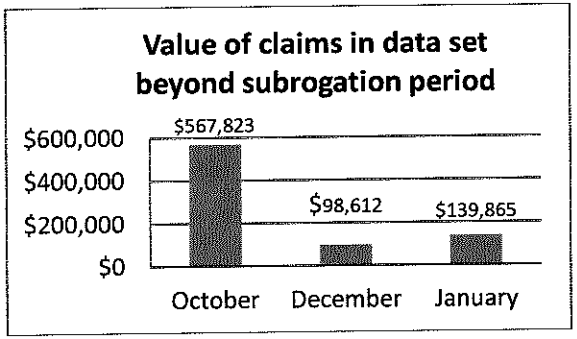


Story behind the baseline: This special project officially began in October 2012 with the goal of identifying and recovering Medicaid payments for members that were also covered by commercial carriers. In 2010, Medicaid paid approximately $78 million in claims that were denied by commercial carriers. HMS recovered $6.8 million through administrative appeals. This project created four positions, three of which were hired by or shortly after the project's start date. The fourth, the Program Manager, began on January 11, 2013. We received our first data set in October 2012, which contained 7,005 claims from 2009 to present representing $8,315,192 in Medicaid payments. The December and January data sets contained 516 claims worth $447,847, and 623 claims worth $590,213, respectively.

Trend: ◄►

How Much Did We Do?

Ability to act on provided data



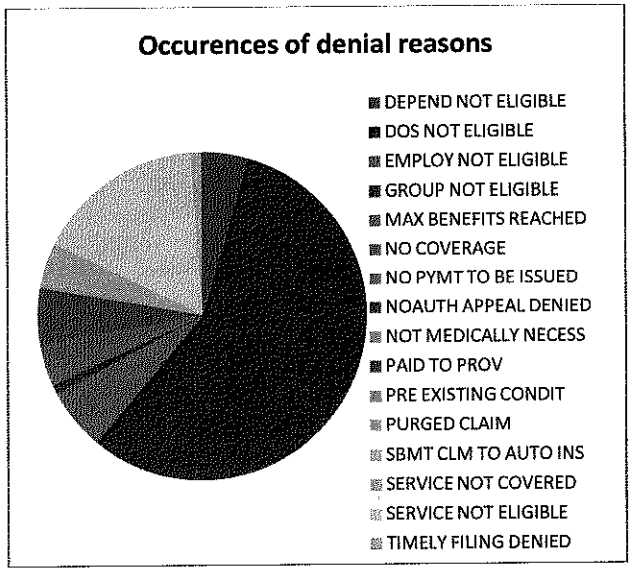
Story behind the baseline: Trend: To date, OHA has received three datasets with 8,144 claims for evaluation. Of those, 773, or 9.5%, of the claims received were beyond the 3 year date range for subrogation. This totaled $806,300, or 8.6%, of the total Medicaid payments OHA could not pursue.

Trend: ◄►

How Well Did We Do It?

Types of claim denials

Story behind the baseline: OHA received data with 17 different denial reasons from 165 different private carriers. 56.5% of the claims received were coded as Date of Service Not Eligible. This classification was found to be inaccurate in many cases. One carrier had 127 claims denied as DOS Not Eligible, but 17 of the dates of service were actually during active enrollment, with $52,644 in Medicaid payments resulting from this erroneous categorization.



Trend: ◄►

2013 Program Report Card: Office of the Healthcare Advocate

Quality of Life Result: All Connecticut residents in the DCF Voluntary Services program will utilize their commercial insurance for medically necessary services

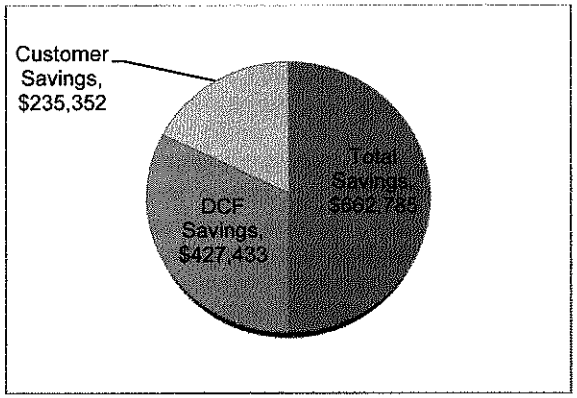
Contribution to the Result: Provide education, counseling, direct intervention through appeals on the proper use of commercial insurance before accessing DCF/HUSKY insurance.

Program Expenditures	State Funding	Federal Funding	Other Funding	Total Funding
Actual FY 12	$0	$		$0
Estimated FY 13	$ 101,400.00	$		$ 101,400.00

Partners: Consumers of Connecticut, DCF, DSS, health care providers, health insurance companies.

How Much Did We Do?

Amount of State and Customer Savings

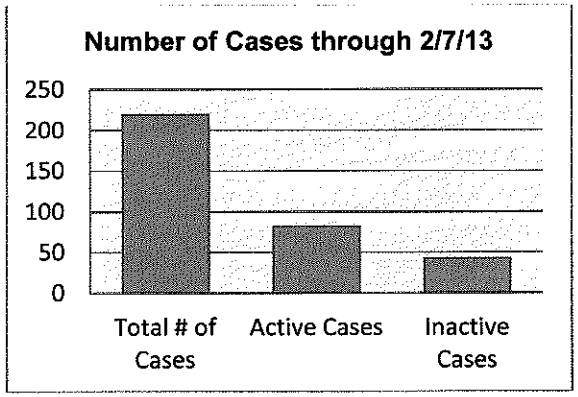


Story behind the baseline: This special project officially began in September 2012 with one position. The trend for savings to the State as well as consumers is anticipated to increase over the next year. Seventeen of the cases have been submitted for appeal and results are pending.

Trend: ▲

How Well Did We Do It?

Number of cases referred by DCF to OHA

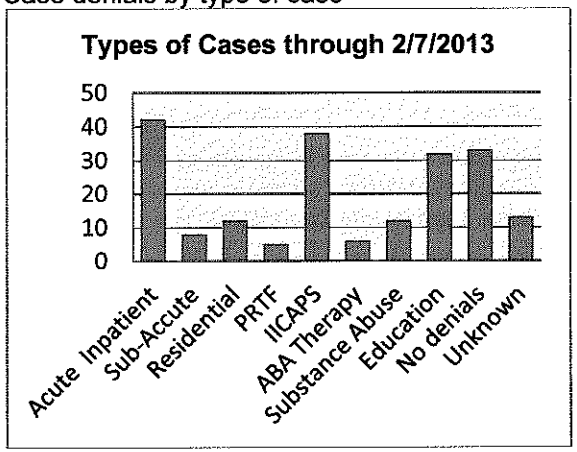


Story behind the baseline: Trend: OHA is receiving DCF Voluntary Services referrals from all DCF regional offices and not all result in appeals of denials. Some cases are education/counseling and are reflected as inactive cases, though OHA has provided those education/counseling services. The trend for the number of all cases is anticipated to increase over the next year and we continue to refine the details of the special project.

Trend: ▲

How Well Did We Do It?

Case denials by type of case



Story behind the baseline: It is anticipated that the types of cases being referred by DCF Voluntary Services will increase and expand in category as this project continues, as OHA and DCF continue to educate customers and denials of coverage in private plans continues. OHA also anticipates an increase in cases once the Health Insurance Exchange plans begin enrolling individuals and offering mental health and substance use services.

Trend: ▲